House of Representatives

General Assembly

File No. 207

February Session, 2014

Substitute House Bill No. 5373

House of Representatives, March 31, 2014

The Committee on Program Review and Investigations reported through REP. MUSHINSKY of the 85th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) On or before May first of each year, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but

not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July first of each year, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision;

(2) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information;

(3) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians, preferred provider

networks and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a risk-sharing arrangement or a capitated risk arrangement;

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its state medical loss ratio and its federal medical loss ratio, as both terms are defined in section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and specialty care provider, the percentage of primary and specialty care providers who are board certified, and how the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner;

(5) A summary of the procedures used by managed care organizations to credential providers; **[**and**]**

(6) A report on claims denial data for lives covered in the state for the prior calendar year, in a format prescribed by the commissioner, that includes: (A) The total number of claims received; (B) the total number of claims denied; (C) the total number of denials that were appealed; (D) the total number of denials that were reversed upon appeal; (E) (i) the reasons for the denials, including, but not limited to, "not a covered benefit", "not medically necessary" and "not an eligible enrollee", (ii) the total number of times each reason was used, and (iii) the percentage of the total number of denials each reason was used; and (F) other information the commissioner deems necessary; **[**.**]**

(7) A report, by county, on: (A) The estimated prevalence of substance use disorders, as described in section 17a-458, among covered children, young adults and adults; (B) the number and percentage of covered children, young adults and adults, who received covered treatment of a substance use disorder, by level of care provided; (C) the median length of a covered treatment provided to covered children, young adults and adults, for a substance use disorder, by level of care provided; (D) the per member per month claim expenses for covered children, young adults and adults who received covered treatment of substance use disorders; and (E) the number of in-network health care providers who provide treatment of substance use disorders, by level of care and the percentage of such providers who are accepting new clients under such managed care organization's plan or plans. For purposes of this subdivision, "children" means individuals less than sixteen years of age, "young adults" means individuals sixteen years of age or older but less than twenty-six years of age and "adults" means individuals twenty-six years of age or older;

(8) A state-wide report on the number, by licensure type, of health care providers who provide treatment of substance use disorders, co-occurring disorders and mental disorders, who, in the calendar year immediately preceding for the initial report and since the last report submitted to the commissioner for subsequent reports, (A) have applied for in-network status and the percentage of those who were

accepted for such status, and (B) no longer participate in the network;

(9) A state-wide report on the number, by level of care provided, of health care facilities that provide treatment of substance use disorders, co-occurring disorders and mental disorders, that, in the calendar year immediately preceding for the initial report and since the last report submitted to the commissioner for subsequent reports, (A) have applied for in-network status and the percentage of those that were accepted for such status, and (B) no longer participate in the network;

(10) A report identifying and explaining factors that may be negatively impacting covered individuals' access to treatment of substance use disorders, including, but not limited to, screening procedures, the supply state-wide of certain categories of health care providers, health care provider capacity limitations and provider reimbursement rates; and

(11) Plans and ongoing or completed activities to address the factors identified in subdivision (10) of this subsection.

(b) (1) The information required pursuant to subsection (a) of this section shall be consistent with the data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS).

(2) A managed care organization may request the commissioner to deem any of the information required pursuant to subdivisions (8) to (11), inclusive, of subsection (a) of this section as confidential and not subject to disclosure under section 1-210. The commissioner shall review such information and make a determination, in writing, to approve or disapprove such request.

(c) The commissioner may accept electronic filing for any of the requirements under this section.

(d) No managed care organization shall be liable for a claim arising out of the submission of any information concerning complaints concerning providers, provided the managed care organization

submitted the information in good faith.

(e) The information required under subdivision (6) of subsection (a) of this section shall be posted on the Insurance Department's Internet web site.

Sec. 2. Section 38a-478*l* of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Not later than October fifteenth of each year, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all managed care organizations. The commissioner shall develop the consumer report card in a manner permitting consumer comparison across organizations.

(b) (1) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include (A) all health care centers licensed pursuant to chapter 698a, (B) the fifteen largest licensed health insurers that use provider networks and that are not included in subparagraph (A) of this subdivision, (C) the state medical loss ratio of each such health care center or licensed health insurer, (D) the federal medical loss ratio of each such health care center or licensed health insurer, (E) the information required under **[**subdivision**]** subdivisions (6) and (7) of subsection (a) of section 38a-478c, as amended by this act, and (F) the information **[**concerning mental health services, as specified in**]** required under subsection (c) of this section. The insurers selected pursuant to subparagraph (B) of this subdivision shall be selected on the basis of Connecticut direct written health premiums from such network plans.

(2) For the purposes of this section and sections 38a-477c, 38a-478c, as amended by this act, and 38a-478g:

(A) "State medical loss ratio" means the ratio of incurred claims to

earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features;

(B) "Federal medical loss ratio" has the same meaning as provided in, and shall be calculated in accordance with, the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(c) **[**With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay.**]** (1) On or before May first of each year, each health insurer that writes health insurance in this state shall submit to the commissioner:

(A) Data for benefit requests, utilization review of benefit requests, adverse determinations and final adverse determinations, for the treatment of substance use disorders, co-occurring disorders and mental disorders: (i) Grouped according to levels of care, including, but not limited to, inpatient, outpatient, residential care and partial hospitalization; (ii) grouped by category for substance use disorders, co-occurring disorders and mental disorders; and (iii) grouped by children, young adults and adults. For purposes of this subparagraph, "children" means individuals less than sixteen years of age, "young adults" means individuals sixteen years of age or older but less than twenty-six years of age and "adults" means individuals twenty-six years of age or older; and

(B) Data for external appeals for the treatment of substance use disorders, co-occurring disorders and mental disorders, as set forth in subparagraphs (A)(i) to (A)(iii), inclusive, of this subdivision.

(2) Such data shall be collected in a manner consistent with the

National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS) measures.

(d) The commissioner shall test market a draft of the consumer report card prior to its publication and distribution. As a result of such test marketing, the commissioner may make any necessary modification to its form or substance. The Insurance Department shall prominently display a link to the consumer report card on the department's Internet web site.

(e) The commissioner shall analyze annually the data submitted under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of this section for the accuracy of, trends in and statistically significant differences in such data among the health care centers and licensed health insurers included in the consumer report card. The commissioner may investigate any such differences to determine whether further action by the commissioner is warranted.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2014*	38a-478c
Sec. 2	*October 1, 2014*	38a-478*l*

PRI *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill requires managed care organizations and insurance companies to report additional data to the Insurance Department. As this concerns reporting by private entities, there is no fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5373

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.

SUMMARY:

This bill expands the information that managed care organizations (MCOs) and health insurers must report to the insurance commissioner by May 1 annually. The bill also expands the information the insurance commissioner must publish by October 15 annually in the Consumer Report Card on Health Insurance Carriers in Connecticut. The information to be reported and published relates to substance use and mental disorders.

An MCO that fails to file the required information is subject to a fine of $100 for each day the report is late (CGS § 38a-478b). The bill does not specify a penalty for health insurers who fail to file the required information, thus, the general statutory penalty applies. That penalty allows the commissioner to fine the insurer up to $15,000 (CGS § 38a-2).

The bill allows an MCO to ask the commissioner to consider some of the reported information confidential and not subject to disclosure under the Freedom of Information Act (FOIA). The commissioner must review the information and approve or disapprove the request in writing. But the effect of the commissioner's approval is unclear. By law, a person denied the right to inspect or copy a public record may appeal to the Freedom of Information Commission (FOIC), which may order disclosure of the record. Because the bill does not explicitly exempt the information from disclosure under FOIA, it appears that

the FOIC could order it to be disclosed even if the commissioner determines it is confidential.

EFFECTIVE DATE: October 1, 2014

MANAGED CARE ORGANIZATION

By law, an "MCO" is an insurer, health care center (i.e., HMO), hospital or medical service corporation, or other organization delivering, issuing, renewing, amending, or continuing an individual or group health managed care plan in the state. A "managed care plan" is a product an MCO offers that finances or delivers health care services to plan enrollees through a network of participating providers.

The bill requires MCOs to report to the insurance commissioner by May 1 annually, by county, the:

1. estimated prevalence of substance use disorders among covered children (under age 16), young adults (age 16 to 25), and adults (age 26 and older);

2. number and percentage of covered children, young adults, and adults who received covered treatment for a substance use disorder, by level of care provided (e.g., inpatient, outpatient, residential care, and partial hospitalization);

3. median length of covered treatment provided to covered children, young adults, and adults for a substance use disorder, by level of care provided;

4. per member per month claim expenses for covered children, young adults, and adults who received covered treatment for substance use disorders; and

5. number of in-network health care providers who provide substance use disorder treatment, by level of care, and the percentage of such providers who are accepting new clients under the MCO's plans.

The bill requires the commissioner to include the above information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut.

The bill also requires MCOs to report to the commissioner by May 1 annually:

1. the number, by licensure type, of health care providers who treat substance use disorders, co-occurring disorders, and mental disorders, who, in the preceding calendar year (a) applied for in-network status, and the percentage who were accepted, and (b) no longer participated in the network;

2. the number, by level of care provided, of health care facilities that treat substance use disorders, co-occurring disorders, and mental disorders, that, in the preceding calendar year (a) applied for in-network status, and the percentage that were accepted, and (b) no longer participated in the network;

3. factors that may negatively affect covered enrollees' access to substance use disorder treatment, including screening procedures, the supply of health care providers and their capacity limitations, and provider reimbursement rates; and

4. plans and ongoing or completed activities to address the identified factors.

Under the bill, an MCO may ask the commissioner to consider the above four reported items confidential and not subject to disclosure under FOIA. The commissioner must review the information and determine, in writing, to approve or disapprove the request.

HEALTH INSURER

The bill requires each health insurer that writes health insurance policies in Connecticut to report to the insurance commissioner by May 1 annually data on benefit requests, utilization review of benefit requests, adverse determinations, final adverse determinations, and

external appeals, for the treatment of substance use disorders, co-occurring disorders, and mental disorders. The information must be grouped by (1) the level of care, (2) category, and (3) age group (i.e., children, young adult, and adults).

The bill requires the commissioner to include this information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute
Yea 11 Nay 0 (03/13/2014)